



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

TENNESSEE BOARD OF OSTEOPATHIC EXAMINERS  
COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384  
[www.tennessee.gov/health](http://www.tennessee.gov/health)

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A MIDWIFE  
APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee certificate to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Council.**

1. Complete, sign, have notarized, and mail the application pages 1 through 6. \_\_\_\_\_
2. Attach to the application a clear, recognizable, recently taken passport photograph of yourself. \_\_\_\_\_
3. If you are or have ever been licensed, certified, registered, or permitted by any state or country to practice as a Midwife or other health professional, you must complete and mail Attachment 1 to each and every state. Copies of Attachment 1 may be duplicated to accommodate each request. \_\_\_\_\_
4. Certification from NARM is a requirement. You must complete and mail Attachment 2 to the NARM office. \_\_\_\_\_
5. Submit two (2) original letters of recommendation from persons who can attest to your character as a Midwife. One (1) of the required letters shall be submitted from a health care professional. No letters from family members or relatives shall be accepted. These letters **must be originals** on the signator's letterhead. \_\_\_\_\_
6. Attach to the application a check or money order in the amount of \$1,010 made payable to the Council of Certified Professional Midwifery. \_\_\_\_\_
7. Submit proof of current CPR certification including infant or neonatal resuscitation. A notarized photocopy of current CPR certification attached to the application will be sufficient. \_\_\_\_\_
8. All applicants for initial licensure in Tennessee must obtain a criminal background check. For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>. \_\_\_\_\_
9. Complete Declaration of Citizenship. \_\_\_\_\_

## UNDERSTANDING THE APPLICATION PROCESS

**If an address change occurs at any time, you must notify the Council's administrative office, in writing, immediately.**

1. All application fees are non-refundable.
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:  
  
Tennessee Board of Osteopathic Examination  
Council of Certified Professional Midwifery  
665 Mainstream Drive  
Nashville, TN 37243
3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Council asks that you please give the administrative office every consideration in this matter.
4. If necessary documentation has not been received when your application has been received by the Council's administrative office, an initial deficiency letter will be sent to you. The supporting documentation requested in the letter must be received in the Council's administrative office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.
5. Absent any complicating factors, the average application processing time is six (6) weeks. Once the application is completed, your file will be promptly reviewed and an initial certification determination made. You will be promptly notified by letter of the initial determination and if your application is approved you will be able to view certification approval on the Internet.
6. It is strongly recommended that you do not make arrangements to accept employment as a Certified Professional Midwife in Tennessee until you are granted certification by the Council of Certified Professional Midwifery.
7. You have the option to receive all correspondence from the Department of Health electronically. Should you "opt in," you will no longer receive physical mail from this office. Opting in does not discharge your obligation to provide the Department with a current physical address and email address. You are required by statute and rule to notify the Department of an address change within thirty (30) days of any such change.
8. All documents which are provided to this office in conjunction with your request for a medical license becomes part of the public record and must be released pursuant to a public records request.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

**IMPORTANT: You must have a Tennessee certificate issued by the Council of Certified Professional Midwifery in your possession before you may lawfully practice.**



**FOR OFFICIAL USE  
ONLY**

**ATTACH A  
CURRENT FULL-  
FACE  
PHOTOGRAPH**

**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243**

**3045-001 \$ 500  
3045-006 \$ 10  
\$ 510**

**BOARD OF OSTEOPATHIC EXAMINATION  
COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384  
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**APPLICATION FOR  
CERTIFIED PROFESSIONAL MIDWIFE IN TENNESSEE**

**PERSONAL INFORMATION**

Name as it will appear on license: \_\_\_\_\_  
(First) (Middle) (Last)

Have you been known by any other name? Y N If yes, list names: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Yr. \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

U.S. Citizen: Y N Gender: M F Race: \_\_\_\_\_

Are you entitled to Live and Work in U.S.? Y N

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? Y N (If yes, please provide proof of status.)

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component Y N (If yes, please provide proof of same.)

Present Mailing Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Do you wish to receive notification, including renewal notification, from the Department of Health via email? Y N

**Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office.**

## EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond high school. Use the back of this page if you need additional space.

From:		To:			
	<i>MM/YY</i>		<i>MM/YY</i>	Educational Institution	Location
From:		To:			
	<i>MM/YY</i>		<i>MM/YY</i>	Educational Institution	Location
From:		To:			
	<i>MM/YY</i>		<i>MM/YY</i>	Educational Institution	Location
From:		To:			
	<i>MM/YY</i>		<i>MM/YY</i>	Educational Institution	Location

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

<u>DATES</u>		<u>LOCATION</u>	<u>POSITION AND DUTIES</u>
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)
From:		To:	
	<i>MM/YY</i>		<i>MM/YY</i>
		(City)	(State)

## LICENSURE INFORMATION

**YES   NO**

Are you or have you ever been licensed in this profession in another state?

\_\_\_\_\_

Are you or have you ever been licensed in any other profession in Tennessee or another state?

\_\_\_\_\_

List below all states, countries or provinces in which you have ever been or currently are licensed, permitted or certified. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**YES   NO**

Have you previously applied for a license to practice as a midwife in Tennessee?

\_\_\_\_\_

If you have an NPI number, please provide \_\_\_\_\_

## COMPETENCY INFORMATION

**PLEASE ANSWER THE FOLLOWING QUESTIONS.** If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
  - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
  - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
  - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

### QUESTIONS

YES NO

1. Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice? \_\_\_\_\_
2. Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? \_\_\_\_\_

If so, please list: \_\_\_\_\_

*[If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued whether conditions should be imposed or whether you are not eligible for licensure.]*

# **COMPETENCY INFORMATION CONTINUED**

**QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.**

		<b>YES</b>	<b>NO</b>
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	___	___
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	___	___
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	___	___
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice midwifery in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	___	___
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	___	___
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	___	___
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	___	___
10.	Have you ever been rejected or censured by a professional association or society?	___	___
11.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you;	___	___
	b. Have you ever entered into any settlement of any legal action; or	___	___
	c. Are there any legal actions pending against you or to which you are a party?	___	___
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	___	___
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	___	___
14.	Have you ever failed a licensure or certification examination?	___	___
	If yes, which exam and how many times have you failed? _____	___	___

## AFFIDAVIT AND RELEASE

I, \_\_\_\_\_, of \_\_\_\_\_,  
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application and signed photos attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations, which were enclosed in the application packet, and agree to abide by them in the practice of my profession in the State of Tennessee.

### I HEREBY:

**SIGNIFY** my willingness to appear to answer such questions as the Board may find necessary, which may include an interview.

**RELEASE** to the Council and Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

**AUTHORIZE** the Council and Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and any other qualifications.

**RELEASE** from liability the Council and Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications for licensure.

**ACKNOWLEDGE** that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

**AUTHORIZE** release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

**THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE



ATTACHMENT 1



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243

COUNCIL OF CERTIFIED PROFESSIONAL MIDWIFERY  
(800) 778-4123, ext. 532-4384 or (615) 532-3202, ext. 532-4384  
[www.tennessee.gov/health](http://www.tennessee.gov/health)

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

**APPLICANT:** Please provide the information requested in the top box and then mail one (1) form to the licensure board in EACH state where you **hold or have ever held** a license to practice any profession. (Copies of this form can be used). **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

**To Be Completed By Applicant (Please Print In Ink)**

I, the undersigned applicant, was granted a license or certificate to practice \_\_\_\_\_  
(Profession)  
numbered \_\_\_\_\_ on \_\_\_\_\_ in the State of \_\_\_\_\_.  
(Date)

The Council of Certified Professional Midwifery of Tennessee requests that I submit evidence of the current status of that license in your state.

You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Council of Certified Professional Midwifery.

Date \_\_\_\_\_

Applicant's Signature

Applicant's typed or printed name

**To Be Completed By Administrative Office of State Licensure Board**

Name In Full As it Appears On License/Certificate or Permit:

\_\_\_\_\_  
(First) (M.I.) (Last)

License/Certificate/Permit Number: \_\_\_\_\_ Profession: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Basis of Issuance: \_\_\_\_\_ Endorsement/Reciprocity with \_\_\_\_\_  
(Check One) (State)

\_\_\_\_\_ Written Examination \_\_\_\_\_

Is the license currently active and registered? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there any derogatory information on file? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please attach supporting documentation.

Authorized Signature

Title

Date

Please mail directly to: Council of Certified Professional Midwifery  
665 Mainstream Drive  
Nashville, TN 37243



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
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**NARM VERIFICATION**

Please complete this form and mail it to the address below:

**Send to:**

**North American Registry of Midwives  
P.O. Box 7703  
Little Rock, AR 72217-7703**

**To Be Completed By Applicant (Please Print In Ink)**

Dear NARM Official:

I am applying for a certificate to practice as a Certified Professional Midwife in the State of Tennessee. The State Board of Osteopathic Examiners' Council of Certified Professional Midwifery requires that a credential letter be **forwarded directly to their** office by the NARM.

Applicant's Name: \_\_\_\_\_  
(First) (Middle) (Last)

Applicant's Address: \_\_\_\_\_  
(Street, City, State, Zip)

Social Security No.: \_\_\_\_\_ - - \_\_\_\_\_ Credential # \_\_\_\_\_

\_\_\_\_\_  
Signature

**PLEASE MAIL CREDENTIAL VERIFICATION DIRECTLY TO:**

**Council of Certified Professional Midwifery  
665 Mainstream Drive  
Nashville, TN 37243**



**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
HEALTH RELATED BOARDS  
665 MAINSTREAM DRIVE  
NASHVILLE, TN 37243**

**DECLARATION OF CITIZENSHIP  
MUST ACCOMPANY ALL APPLICATIONS FOR INITIAL LICENSURE OR REINSTATEMENT OF LICENSURE**

The "SAVE Act" requires Tennessee Department of Health (including all Boards, Commissions, and contractors), along with every local health department in the State, to verify that *every adult* applicant for a professional license is either a U.S. citizen, a "qualified alien," or a nonimmigrant who meets the requirements set out at 8 U.S.C. 1621.

I am a(n) \_\_\_\_\_  
**Healthcare Profession (Please Print) License number if applicable**

**Please Print Legibly**

1. Name: \_\_\_\_\_  
                     Last                      First                      Middle                      Maiden\_
2. Mailing Address: \_\_\_\_\_
3. Phone Number: Home: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Office: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_

4. I am a United States Citizen:    \_\_\_\_Yes    \_\_\_\_No
5. I am a foreign national not physically present in the United States \_\_\_\_Yes \_\_\_\_No. If you answered yes, to this question please sign this form in the presence of a notary and return it with your application. No further documentation is required.
6. Applicants Claiming United States Citizenship **MUST** provide one of the following:
  - a) Tennessee Driver's License, or photo ID issued by the Tennessee Department of Safety.
  - b) A valid driver license or ID issued by another state, provided its issuance requirements meet Tennessee Department of Safety criteria.
  - c) An official birth certificate issued by a U.S. state, territory, or other jurisdiction. Puerto Rican birth certificates issued before July 1, 2010 do not qualify.
  - d) A federally issued birth certificate.
  - e) A valid, unexpired U.S. passport.
  - f) A report of birth abroad of a U.S. citizen.
  - g) A certificate of citizenship.
  - h) A certificate of naturalization.
  - i) A U.S. citizen ID card.
  - j) Any successor document to #'s e-i above.
  - k) An SSN that is verifiable with the Social Security Administration in accordance with federal law.
7. If you checked "No" in question 4 please indicate from the list below which category applies to you: (circle one)
  - a) Permanent Resident
  - b) A nonimmigrant applicant for a professional or commercial license whose visa for entry into the United States is related to such employment, or a nonimmigrant under the Immigration and Nationality Act (8 U.S.C. 1101 *et seq.*).
  - c) Asylees who meet the qualifications set out in 8 U.S.C. 1158
  - d) Refugees who meet the qualifications set out in 8 U.S.C. 1157

- e) Persons who have been "paroled into the United States," under 8 U.S.C. 1182(d)(5) or whose deportation has been withheld under 8 U.S.C. 1253.
- f) Cuban or Haitian entrants as defined by section 501(e) of the Refugee Education Assistance Act of 1980
- g) Persons granted conditional entry into the U.S. under 8 U.S.C. 1153(a)(7) before April 1, 1980, because of persecution or fear of persecution on account of race, religion, or political opinion or because of being uprooted by catastrophic national calamity.
- h) An alien who has been "battered" or subjected to "extreme cruelty" by a parent or spouse as defined by 8 U.S.C. 1641(c), and also meets the qualifications set out 8 U.S.C. 1641(c)(1)(B). Under the circumstances set out in 8 U.S.C. 1641(c)(2) and (3), victims' children, or the parents of children who are victims, may also apply for benefits as qualified aliens.

Applicants claiming **qualified alien status** (question 7 above), please submit two of the following forms of "documentation of identity and immigration status" as determined by U.S. Homeland Security to be acceptable for verification through the SAVE program. Common types of documents used to verify immigration status are listed below. (Note: If you can provide only one document, your status will be verified through the U.S. Department of Homeland Security's SAVE program):

I-327 (Reentry Permit)

I-551 (Permanent Resident Card or "Green Card")

I-571 (Refugee Travel Document)

I-766 (Employment Authorization Card)

Machine Readable Immigrant Visa (with Temporary I-551 language)

Temporary I-551 stamp (on passport or I-94)

I-94 (Arrival/Departure record)

Unexpired foreign passport

WT/WB Admission Stamp in unexpired foreign passport

I-20 (Certificate of Eligibility for Nonimmigrant F(1) student status-- "student visa")

DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)

I affirm under the penalty of perjury that the above is true and correct.

Signed this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature

Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

AFFIX SEAL HERE

My Commission Expires: \_\_\_\_\_

**If an applicant is discovered to be an unqualified alien, or otherwise ineligible for benefits under the Act, all recurring benefits provided to that applicant must be immediately terminated. Anyone who purposefully makes a false, fictitious, or fraudulent claim of U.S. citizenship or qualified alien status will be liable under the Tennessee Medicaid False Claims Act, or Tennessee's False Claims Act. Any person who conspires to defraud the state or any local health department by securing a false claim allowed or paid to another person in violation of the Act may be liable under Tennessee's False Claims Act. Upon discovery of an applicant's false, fictitious, or fraudulent claim of citizenship or alien status, state governmental entities and local health departments must also file a criminal complaint with the United States Attorney and/or the Office of the Attorney General.**